THE INTEGRATION OF DEPENDENT HANDICAPPED STUDENTS

A study guide to the second program in the ACCESS television inservice series
ONE GIANT STEP: The Integration of Children With Special Needs

ACCESS NETWORK

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ONE GIANT STEP: The Integration of Children With Special Needs is a ten-program, inservice series of videotapes. Each videotape has a running time of 15:00 minutes and is supplemented by a study guide. The program order numbers and titles are:

BPN 2154
01 Introduction
02 The Integration of Dependent Handicapped Students
03 The Integration of Trainable Mentally Handicapped Students
04 The Integration of Educable Mentally Handicapped Students
05 The Integration of Learning Disabled Students
06 The Integration of Visually Impaired Students
07 The Integration of Hearing Impaired Students
08 The Integration of Physically Handicapped Students
09 The Integration of Gifted Students
10 The Integration of Behaviorally Disordered Students

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PROGRAM SUMMARY

This program presents a positive, yet sensitive, view of how dependent handicapped (DH) students can be integrated into a regular school setting, as well as helped to function in their unique family and community environments.

Dale, a young adult attending an integrated school, shows how dependent handicapped students can achieve dignity and self-worth through structured teaching and a team approach. Myths regarding acceptance of DH students are dispelled through interviews with Dale's parents, the school administration, his teacher, and regular students.

David, another dependent handicapped student, is taught using a transdisciplinary approach. Together with his special-education teacher and an occupational therapist, his needs are met within a school setting.

Other DH students are taught by their special-education teacher with assistance from a speech pathologist, an occupational therapist, and a special-education consultant from a school system. Interaction with their peers takes place and is supported in both an academic and a non-academic milieu.

PROGRAM GOALS AND OBJECTIVES

This program is designed to assist teachers, school administrators, parents, and others involved with the handicapped to gain background information on DH students. It can be used as a base for effective integration of these students into the regular school environment.

As a result of inservice, participants will be able to:

1. define "dependent handicapped" and identify the developmental characteristics of DH students in terms of:
   - **a.** delayed motor skills,
   - **b.** physical characteristics/conditions,
   - **c.** socio-emotional characteristics.
2. identify principles of education for DH students.
3. identify the relevance of the Cascade Service Delivery Model in integrating these students.
4. describe at least four teaching techniques that can be used in teaching DH students in an integrated setting.
5. list, and describe in general terms, resources, support services, and programs necessary to facilitate the education and integration of DH students.

BACKGROUND INFORMATION FOR THE TEACHER OR WORKSHOP LEADER

The dependent handicapped student is defined by the degree of handicap, rather than the handicapping condition. This student is so severely handicapped that a lifetime of intensive instruction and ongoing supervision is required, hence a dependence upon others for existence, e.g., basic life skills. Most DH students are profoundly mentally handicapped, having an intelligence quotient of 30 or less.

CHARACTERISTICS OF THE DEPENDENT HANDICAPPED STUDENT

1. Developmental characteristics

- **a.** Many DH students cannot walk by themselves and require the use of wheelchairs, walkers, braces or support canes.
- **b.** Some have not achieved the "basics" in motor development, e.g., holding up the head, grasping objects, rolling over. Movement may be limited due to contracted, flaccid, or underdeveloped muscles.
- **c.** Some may not have apparent motor-skill impairments, while others are virtually immobile.

2. Physical characteristics/conditions

- **a.** Some have epileptic seizures ranging from mild to severe, with side effects from seizure-control medication, e.g., swollen gums, drowsiness.
- **b.** Some have frequent respiratory and ear infections.
- **c.** Skin rashes are common due to incontinence and non-ambulation.
- **d.** Many have extensive visual and auditory impairments, singly or in combination, and/or faulty perception.

3. Socio-emotional characteristics

a. ***Self-help.*** Most DH students lack fundamental self-help and survival skills. Due to physical and neurological damage and/or profound developmental delay, many are not toilet trained. Other skills such as feeding, dressing, and general hygiene may be absent or only partially developed.

b. ***Socialization.*** Dependent handicapped students are often not aware of their own bodies and do not know their own names. They must first become aware of themselves before they can interact with others. Yet interaction experiences are often denied these students. Their delayed development, different behavior, and physical appearance frighten people or evoke inappropriate social responses, e.g., pity.

c. ***Language development.*** Dependent handicapped students show speech and language deficiency. They have little expressive language: no speech, just several words, or short phrases. Brain damage often affects speech clarity. Receptive language is poor. Often these students understand little of what is said to them. This lack of communication results in frustration for them and often leads to undesirable means of communication, e.g., tantrums, crying, aggressive behavior.

PRINCIPLES OF EDUCATION FOR THE DEPENDENT HANDICAPPED STUDENT

1. Dignity of the student

Care must be taken so that the severity of the student's handicap does not detract from self-image. The DH student should be treated with consideration and respect *at all times,* and should be well-dressed and well-groomed. Steps should be taken to ensure personal privacy whenever possible. Attempts should be made to consult the student regarding wishes, choices, and decisions. Like others, this student must have the freedom to make mistakes as well as experience success.

2. Developmental focus

For dependent handicapped students, learning does not always follow established patterns. However, it is important to recognize that development continues throughout life, and the rate and level of learning can be greatly influenced by systematic training.

3. Normalization and continuum of services

DH students should be allowed to develop to their maximum potential under the most normal conditions possible. Care should be taken to provide an age-appropriate curriculum in the least restrictive environment.

Intervention with this child begins at birth, the parents being a primary source of information regarding skills and needs. Early inattention to physical or sensory disabilities causes serious problems later on. Programs should begin at home and continue into school years, with an awareness of the long-term nature of training. At a minimum, there should be a move from preschool to elementary, and from elementary to a more advanced education leading to a community-based education.

Assessment and programming should be trans-disciplinary, e.g., speech therapy, physiotherapy, occupational therapy, medical and psychological assessment.

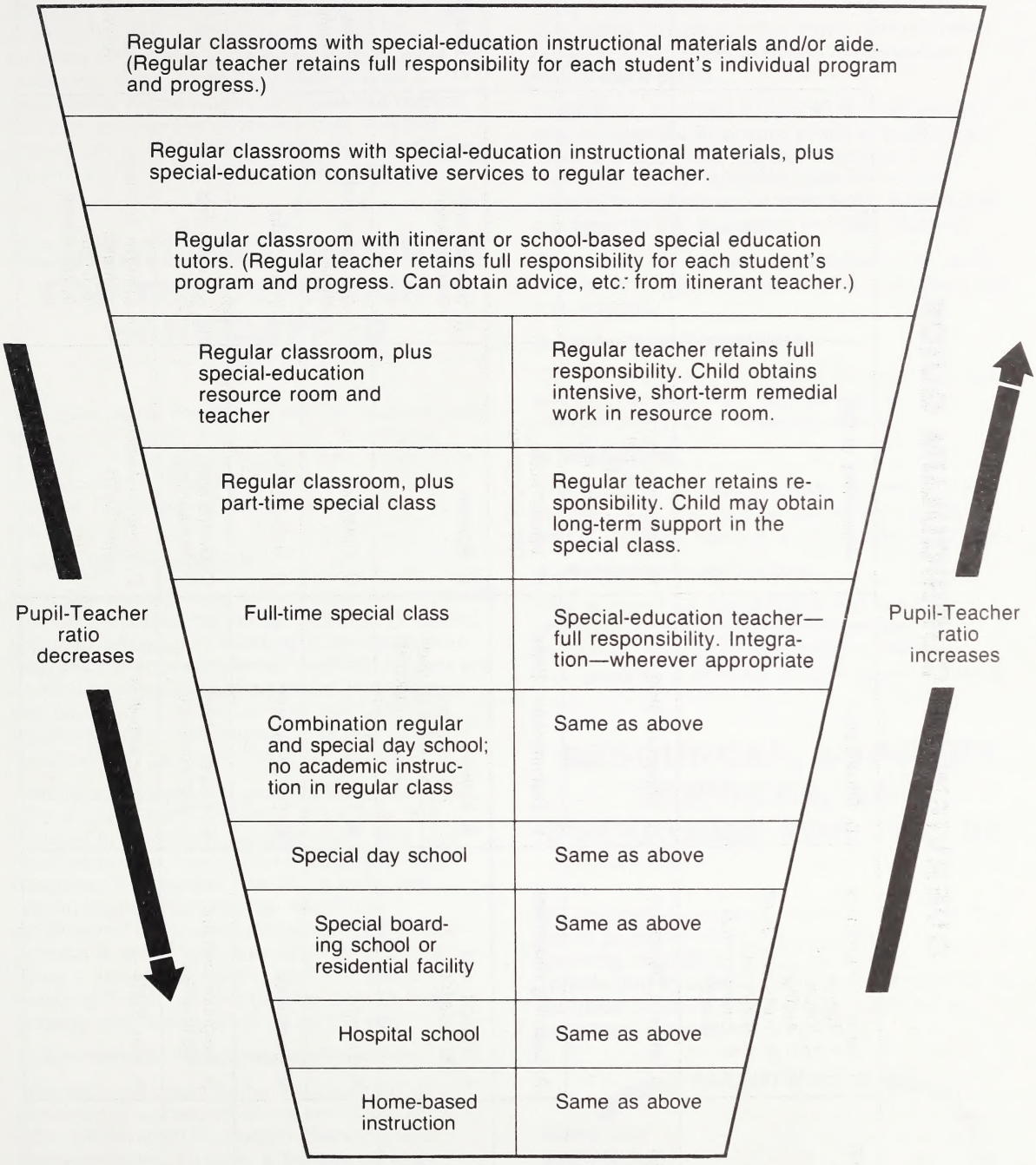
THE CASCADE SERVICE DELIVERY MODEL

Integration is viewed along a continuum ranging from segregated institutional settings to full-time placement in regular classrooms with all the intermediate steps suggested in the Cascade Service Delivery Model.

Integration should occur only after a careful assessment of the student, the proposed school environment, and the support services available. The student should be placed in a realistic situation while receiving education. These needs may change as this student progresses.

Not all DH students will be able to function full-time in a regular school setting. Even in segregated, special facilities they can be integrated to some degree through the use of volunteers, community service groups, etc. These students can eat in the school lunchroom with regular students, take part in school assemblies and, where possible, participate in such non-academic subjects as music.

CASCADE SERVICE DELIVERY MODEL*



*Adapted from the Reynolds framework (1962)[1], the Dunn model (1963)[2], and the Deno cascade model of special education services[3].

[1]Reynolds, Maynard C. "A Framework for Considering Some Issues in Special Education" in **Exceptional Children,** Vol. 28, No. 7, March 1962, p. 368.

[2]Dunn, Lloyd M., *ed.* **Exceptional Children in the Schools: Special Education in Transition.** New York: Holt, Rinehart, Winston, 1963, p. 37.

[3]Deno, Evelyn. "Special Education as Developmental Capital" in **Exceptional Children,** Vol. 37, No. 3, November, 1970, p. 235.

OVERVIEW OF CURRICULUM GUIDE

AWARENESS AND SOCIALIZATION	A. Sensory Awareness 1. Tactile 2. Visual 3. Auditory 4. Taste and Smell 5. Movement 6. Environmental Search	B. Socialization	C. Awareness of Self		
COMMUNICATION	A. General Objectives	B. Receptive Skills	C. Expressive Skills 1. Non-verbal expression 2. Verbal expression		
CONCEPT FORMATION	A. Learning Readiness	B. Discrimination Skills	C. Visual/Tactile Discriminations		
MOTOR SKILLS	A. Strength and Endurance	B. Mobility 1. Ambulation 2. Wheelchair and alternate mobility	C. Posture	D. Balance and Co-ordination	E. Fine Motor
SELF-CARE	A. Eating	B. Toileting	C. Dressing	D. Grooming and Hygiene	E. Personal Health Care
PURPOSEFUL ACTIVITIES	A. Orientation	B. Daily Routines	C. Home Skills	D. Work Skills	
COMMUNITY SKILLS	A. Neighborhood and Visiting Skills	B. Travel Safety/ Transportation	C. Stores and Restaurants	D. Activities and Field Trips	
RECREATION	A. Play Skills	B. Water Activities	C. Physical Activities and Sports	D. Creative Activities 1. Music 2. Crafts 3. Movement	E. Leisure Activities

Integration of these children begins, as with any child, in the very earliest years of life. The measure of keeping up or doing exactly what others are doing is not *the* priority. What *is* important is that this child will have the opportunity to perform like other children. The DH student can begin with the peer group and go as far and as fast with them as ability permits.

EDUCATIONAL PROGRAM FOR THE DEPENDENT HANDICAPPED

The educational program of the DH student goes beyond that which is considered "traditional schooling." The preceding overview, taken from the *Dependent Handicapped Curriculum Guide* (Alberta Education, 1983), gives topics of instruction.

Teaching Techniques

Most DH students lack fundamental self-help and survival skills such as eating, dressing, grooming, grasping, sitting, and toileting. They need more help and carefully sequenced instruction if they are to acquire these skills. Systematic instructional procedures and comprehensive instructional sequences must be developed as part of the individualized programs for these students.

Teachers or others who instruct them must be able to analyse the nature of the actual task involved in learning a particular skill. The task must be broken down into its parts. It is also necessary to consider how these parts are related so that each can be taught or emphasized separately and sequentially. This process is called task analysis. For example, doing a zipper up could involve the steps of grasping the zipper end (or tag), pulling it up partway, and then pulling up all the way.

1. Systematic teaching approaches

Structure and organization are important in a transdisciplinary model where members of the team are involved in program planning and implementation. To date, a behavioral and functional approach has proven most effective. The teacher must be well-organized, diligent in writing, recording, and updating lesson plans, as well as introducing flexibility and uncertainty into a small portion of the day. The student then will be able to confront novelty, make decisions, and initiate action.

Daily lesson plans should be consistent with long-range objectives. The curriculum overview on page 4 will assist teachers in preparing instructional plans.

In addition, teachers should allow for flexibility and adaptations to ensure effective instruction. Teachers often face special problems in the motivation of DH students because of their inability to communicate effectively. Reinforcers are basic to the instruction of these students.

Once skills are learned, the teacher must build maintenance, generalization, and application into the program.

2. "Hands-on" approach

The teacher physically guides students through steps of behavior that they cannot do independently, e.g., removing a coat.

3. Modelling

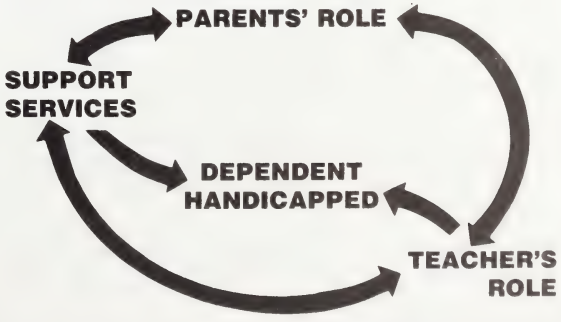
The behavior is demonstrated, and the student imitates. The task can be presented visually and/or verbally. Speech is often taught this way.

4. Behavior-modification

This is based on the principle that behavior is changed by altering the consequences, outcomes, or rewards that follow a behavior, e.g., praising a child for using a spoon correctly.

RESOURCES, SUPPORT SERVICES, AND PROGRAMS FOR THE DH

DH students have many needs to be met if they are to be residents in the community. The following illustration shows the factors contributing to effective educational programming for these students and the inter-relationships necessary for success.



1. Programs for Parents

Severely handicapped children may present behavioral problems that parents are not ordinarily called upon to handle. Day Centre (school) staff, and government agencies such as Services for the Handicapped, (Alberta Social Services and Community Health) can provide support to parents in dealing with problem behavior. Parents and family members also have additional stresses: instructing at home, babysitting services, relief services, and problems of recreation, transportation, financial concern, etc. These family needs can best be met through local parent groups or a buddy system of parents with similar interests.

2. Other specialized services

a. ***Speech pathologists:*** Some are based in Public Health Unit offices; others work directly for large school systems or provide service through hospitals, e.g., the Glenrose Hospital, Edmonton, or the Alberta Children's Hospital, Calgary.

b. ***Psychologists:*** These may be school-based personnel, private practitioners, and/or those working in university clinics or the psychology departments of hospitals.

c. ***Program consultants:*** These are Alberta Education personnel based in regional offices. School systems may have their own program consultants.

d. ***Occupational therapists and physiotherapists:*** Some school jurisdictions employ their own. Service may be available through the Glenrose Hospital, Edmonton, or the Alberta Children's Hospital, Calgary.

PREVIEWING QUESTIONS

These questions are designed to allow the participants to explore their feelings toward DH students. For maximum benefit, it is suggested that the participants discuss one or more questions in small group settings, then share their ideas in the larger group.

1. You see an adult having an epileptic seizure while you are out shopping. His/her friend is having difficulty. A crowd has gathered. What should you do?
2. You want to take a holiday with your husband, but you cannot find anyone with whom to leave your children. Your son has a behavior problem. How do you feel?
3. If you were confined to a wheelchair, what changes would you have to make in your lifestyle? Consider one aspect at a time: home; self-care; recreation, etc.
4. Your new neighbors have a mentally handicapped daughter with a behavior problem. They invite your family over. You wonder if you should go over because you are afraid your children will learn bad behavior. What should you do?
5. Your sister has just had a severely handicapped baby. She and her husband have decided to keep the child. What are your reactions?

PREVIEWING ACTIVITIES

The following activities are intended to allow participants to become aware of what some physical/severe mental handicaps are like, to become aware of some of the problems encountered by dependent handicapped students, and how to overcome some of these problems.

To facilitate the effectiveness of these simulations, it is necessary that the workshop leader be familiar with the activities beforehand. Participants should be organized into small groups and rotated through each of the four activities.

1. Communication

Many people who are dependent handicapped have limited or non-existent oral communication. They experience great frustration in expressing the most basic things, e.g., hunger, love, discomfort.

Materials required: pencils and paper.

Activity: Have the participants form pairs. Ask each participant to select any five words with which to communicate. Instruct one partner to carry on a conversation with the other. Do not allow the use of gestures, body movements, or written language. As a variation, have each participant find out something about their partner *without* using oral or traditional written language.

Invite participants to discuss the following:

How did you feel?

What did you learn about your partner?

What types of words did you select?

2. My Fingers Won't Work

Many DH students experience poor or impaired fine-motor co-ordination. They experience great frustration in not being able to perform simple tasks.

Materials required: heavy work socks (one pair per participant); scissors (one pair per participant); paper; paper clips; clothes pins.

Activity: Have the participants put their hands in the work socks. Then ask them to:

a. untie/tie their shoes
b. fold paper
c. button or zip an article of clothing
d. pick up a small object from the floor, e.g. coin, paper clip
e. put a clothes pin on the paper.

As a variation, urge participants to complete these tasks within an unrealistic time frame.

Invite participants to discuss the following;

How did you feel when your fingers did not perform as you expected?

How would a handicapped student feel when pressured to complete such tasks?

3. Feed Me

Many DH students lack the motor responses to accomplish basic, self-help skills due to profound delayed development or serious physical handicaps.

Materials required: fruit (one of each: oranges, apples, bananas); knives; glasses; water.

Activity: Have the participants form pairs. Give them the following instructions:

A feeds B in any manner agreed upon;
B must not use any hands in this task;
A must eat own food.

Then the partners switch roles. Ask the "dependent" partner to do a paper-and-pencil activity such as name printing, coloring, drawing, or to perform a self-help activity such as handling dishes, picking up toys or small objects.

Ask participants to discuss the following:

How did it feel to be fed?

How could you help the "dependent" person have more self-esteem?

4. I Want To Join In, Too

Many DH students are multi-handicapped. In addition to severe mental retardation, there is a lack of such basic motor responses as grasping, protective reflexes, sitting, ambulation.

Materials required: small balls (one per two participants); situation cards (one per group)

Activity: Have the participants form pairs. Distribute balls and situation cards (see sample below) to each pair. Give them the following directions.

A is to take on the role of the person described in the situation card.
B is to "play catch" with A.

Ask participants to discuss the following:

How did it feel to be A? To be B?

What adaptations did you make to the game so that interaction could take place?

As a variation, have the partners switch roles.

Ask participants to discuss the following:

How did you feel as A? As B?

How could interaction between A and B be enhanced?

SITUATION CARD

1. You can grasp a small object, and your arms and legs work, although responses are extremely delayed.
2. You cannot sit up, but have head control in a lying position, frontwards, backwards, and sideways. Eye-hand co-ordination is developing.
3. The lower part of your body is paralysed.
4. You have jerky gross-motor movements (arms and legs), and your fingers are stiff and extended.
5. Your motor responses work, but you do not hear well and have limited understanding.
6. You can sit up, but are not ambulatory. One arm is affected by cerebral palsy, and you cannot control its movement.

POST-VIEWING QUESTIONS

These questions are designed to reinforce the goals of this program. The questions can be directed either to a total audience or to small groups.

1. What does Dale have in common with his normal peers? In what ways is his interaction in the school beneficial for others?
2. Imagine that your own child is dependent handicapped. What basic expectations would you hold for him/her in life?
3. Your school is contemplating accepting a class of DH students. What preparations would the school need to make for:
   a. acceptance of these students?
   b. interaction between the DH students and teachers?
   c. the layout of the school?
4. Good communication is essential between members of the team responsible for the training of the dependent handicapped. How can this be enhanced?

POST-VIEWING ACTIVITIES

The following activities are intended to give participants practical suggestions on how to experience success when working with DH students. It is recommended that they be carried out in small groups, with reports made later to all the participants.

1. Motivation

Many DH students are difficult to motivate because they have limited communication, limited mobility, and limited experience with achievement. Reinforcers are unique to each individual and change as time passes.

Materials required: pencil and paper; situation cards (see sample below).

Activity: Have the participants form pairs. Hand out paper, pencils, and situation cards. The partners then brainstorm reinforcers.

Ask participants to discuss the following:

Did you feel frustrated with the task?

How could it have been easier?

2. Love Is...Understanding

Many DH students have little receptive understanding, as well as few expressive skills. Selecting a vocabulary with which to communicate is exceedingly difficult. Each person's vocabulary will be slightly different, based upon needs and environment.

Materials required: paper and pencils.

Activity: Have the participants form pairs. Each pair brainstorms to find ten words that will communicate *basic* needs or wants. First, ask them to communicate with each other using the ten words, then add an additional five.

Ask participants to discuss the following:

What frustrations did you experience? How could these be overcome?

What types of words did you select?

How would you teach these words to someone who did not know what they meant?

SITUATION CARD

1. You are a poor eater. You are immobile but seem to see and hear well.
2. You are active but understand little of what is said to you.
3. You are unable to speak and are confined to a wheelchair.
4. You are partially sighted and have limited mobility.
5. You do not respond to your name, or to simple directions.

3. Alternate Forms of Communication

Many DH students do not have oral speech. They must rely on alternate forms of communication such as signs used by the deaf, and graphic modes using pictures or symbols. These modes are often unique due to physical handicaps.

Materials required: paper and pencils; situation cards (see sample below).

Activity: Organize the participants into small groups. Hand out the situation cards and instruct group members to design an appropriate communication mode. Have them communicate using the mode.

Ask participants to discuss the following:

How did you feel using your communication mode? What problems did you have?

What factors need to be considered in selecting or designing a communication system?

4. I Can Learn Too!

Structured teaching can be used successfully by DH students. By breaking tasks down into component steps, using an appropriate teaching technique, and applying suitable reinforcers, they can experience success.

Materials required: paper and pencils; the checklist on page 10.

Activity: Again, organize the participants in small groups. Hand out the materials. Have participants select a simple task—e.g., eating with a spoon—and fill in the appropriate columns of the checklist (task analysis).

Ask participants to discuss the following:

How did you feel about the activity?

Was the activity difficult? How could it be made easier?

How can you maintain the dignity of the DH student while teaching such tasks?

SITUATION CARD

1. Very physically handicapped. Unable to control hand movements.
2. Good gross-motor skills, some fine-motor skills.
3. Nonambulatory.
4. Poor vision. Have use of left side of body only.
5. Hard of hearing..

CHECKLIST

START DATE: _____

TARGET
BEHAVIOR: _____ END DATE: _____

STEPS	SETTING, MATERIALS, INSTRUCTIONS	FEEDBACK, CORRECTION, REINFORCEMENT	CRITERIA FOR ACHIEVEMENT (e.g. 90% 10/R trials)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

GLOSSARY

application. The ability to apply a newly acquired skill to a new situation.

auditory. The ability to use the mode of hearing.

behavioral. A specific instructional goal defined in terms of observable behavior and measurable action.

contracted. As in muscle, shortened or tightened; a reduction in size.

dependent handicapped. Dependent handicapped persons require intensive instruction and ongoing assistance and/or supervision in daily living skills. Motor development, basic communication, and social skills must often be taught within a structured educational environment. The student who is dependent handicapped may have skills and abilities ranging from little mobility to complete ambulation, from an inability to make needs known to adequate communication, from a general unresponsiveness to the environment to goal-directed behavior. Unacceptable behavior may require control or tolerance. Extensive personal and health care may be needed.

epileptic seizures. Paroxysms of involuntary muscular contractions and relaxations due to brain disorder.

expressive language. The ability to put ideas into words. This language is ordinarily spoken, motoric communication.

flaccid. Relaxed, flabby; having absent or defective muscle tone.

functional. Using cues to trigger or control the performance of skills, e.g., self-help skills performed in the kitchen or the bathroom.

generalization. A behavior that is performed under one set of conditions, e.g., school, and also performed in different conditions, e.g., home.

heterogeneous. Unlike traits, as opposed to homogeneous.

incontinence. Inability to retain urine and feces through loss of control, or because of cerebral or spinal lesions.

integration. Getting rid of barriers in an educational/community setting so that the handicapped can participate with their peers.

maintenance. Behavioral term for maintaining or keeping up the performance of a behavior; the occasional reinforcing of behavior.

motor skills. Fine motor as in finger movements, or gross motor as in running.

nonambulation. Inability to walk; confined to a bed.

neurological. Pertaining to tissue that forms the supporting elements of the nervous system.

normalization. To make education for the handicapped as normal as possible.

occupational therapist. Person qualified to improve such adaptive abilities as dressing, eating, use of upper body, and vocational skills.

perception. Interpretation of sensation based on previous experience, through interaction with the environment.

physiotherapist. Person qualified to improve a patient's strength and control of motor functions through neuromuscular activity and exercise.

profoundly mentally handicapped. An I.Q. of 0 - 30.

psychologist. Person who is trained in methods of psychological analysis, therapy, and research.

receptive. Ability to understand language or some other form of communication.

segregated. Separate from others; in education, special-school facilities.

severely mentally handicapped. 0 - 30 I.Q.; intelligence capacity does not exceed that of a 7 - 8 year-old.

socio-emotional. Combined social and emotional behavior needed for effective interaction between persons.

speech pathologist. Person qualified to develop and improve speech and feeding skills.

systematic. Using a system or procedure for developing an educational program.

transdisciplinary. Mutual involvement of many professions in the education program of the handicapped.

visual. Ability to use mode of seeing.

REFERENCES FOR WORKSHOP LEADERS AND TEACHERS

1. Acceptance of the Handicapped

Bookbinder, Susan R. *Mainstreaming.* Boston, Mass.: The Exceptional Parent Press, 1978.

A program for educating children and adults alike about disabilities, with emphasis on the acceptance of differences. Lists activities and resource aids.

Cohen, Shirley, *et al. Accepting Individual Differences.* Niles, Ill.: Developmental Learning Materials, 1977.

The purpose of this kit is to give children a better understanding of what mental and physical handicaps involve, lead children to a greater acceptance of handicapped people, and increase helping behavior.

P.A.T.H. (Positive Attitudes Toward the Handicapped). Calgary, Alta.: Regional Resource Service, Alberta Education, 1978.

This kit contains a variety of materials that encourage a more positive attitude toward, and understanding of, handicapped people. Includes simulation activities and reference materials. (Available from Alberta Education, Calgary Regional Office.)

Ravosa, Carmino C., *et al. Put On A Handicap.* Long Branch, N.J.: Kimbo Educational, 1979.

This record is an aid in preparing a class for mainstreaming. This record gives children the opportunity to experience handicapping conditions by simulation and role-playing.

Ward, Michael J., *et al. Everybody Counts! A Workshop Manual to Increase Awareness of Handicapped People.* Reston, Va.: Council for Exceptional Children, 1979.

A booklet and corresponding tape designed to help people better understand the struggles, frustrations, and triumphs of the handicapped in today's society.

2. General References

Adams, Jane L. *An Education Curriculum for the Moderately, Severely and Profoundly Mentally Handicapped Pupil.* Springfield, Ill.: Charles C. Thomas, 1975. This book consists of teaching objectives and teaching procedures.

Anderson, Daniel R., *et al. Instructional Programming for the Handicapped Student.* Springfield, Ill.: Charles C. Thomas, 1975.

A manual outlining training procedures for a wide variety of tasks including dressing, cleanliness, eating, motor skills and others. Behavior-modification techniques are emphasized, including a discussion of techniques for graphing and recording behavior and implementing behavior-modification techniques.

Bender, Michael, Valetutti, Peter J., and Bender, B. *Teaching the Moderately and Severely Handicapped, Volumes I and II, Behavior, Self-Care and Motor Skills.* Baltimore, Md.: University Park Press, 1976.

This book is an extensive curriculum guide for teaching the mentally retarded, the autistic, the cerebral palsied, the multi-handicapped, and other developmentally disabled persons.

Bluma, S.M. *Portage Guide to Early Education.* Portage, Wisc.: Cooperative Educational Service Agency #12, 1976 rev. ed.

A guide for teachers, aides, nurses, and others who need to assess a child's behavior and plan realistic goals that lead to additional skills. Contains a manual, a checklist, and a card file that aid in assessing preschool behavior and determine target behavior. The *Guide* also suggests techniques to teach each behavior.

Croft, Noel B. *Project Vision-Up Curriculum—A Training Program for Preschool Handicapped Children.* Washington, D.C.: U.S. Department of Health, Education and Welfare, 1976.

A curriculum kit based on the idea that children with and without handicaps appear to follow much the same general patterns of development.

Dependent Handicapped Curriculum Guide. Calgary, Alta.: Alberta Education, 1983.

An outline of topics of instruction, plus suggested teaching strategies and materials. Has a glossary and reference section.

Devore, M. Susan. *Individualized Learning Program for the Profoundly Retarded.* Springfield, Ill.: Charles C. Thomas, 1977.

This book consists of a learning program to teach the profoundly and severely retarded, using praise to increase motivation. Lesson

plans fall into six categories: self-care; social; communicative; cognitive; fine- and gross-motor skills.

Finnie, Nancie R. *Handling the Young Cerebral Palsied Child at Home.* New York, N.Y.: William Heinmann Medical Book, 1974.

The sections in this book dealing with specific techniques are extremely helpful. It can be used by parents and primary care givers in residential settings.

Fredericks, H.D. Bud, *et al. The Teaching Research Curriculum for the Moderately and Severely Handicapped.* Springfield, Ill.: Charles C. Thomas, 1976.

This text provides teachers and parents of the moderately and severely retarded with a complete set of detailed task analyses. The curriculum areas for the task analyses presented include the following skills: self-help; receptive language; expressive language; motor; reading; writing and cognitive. Also recommended for use with the preschool child, the deaf-blind, and those with combined deficiencies.

Kent, Louise. *Language Acquisition Program for the Severely Retarded.* Champaign, Ill.: Research Press, 1974.

Designed to teach a language system to severely retarded individuals, the book is primarily structured for oral administration with hearing and sighted individuals.

Linde, Thomas F., and Kopp, Thushelda. *Training Retarded Babies and Preschoolers.* Springfield, Ill.: Charles C. Thomas 1973.

The purpose of this book is to provide parents, and those who work with them, with ideas and concrete ways of helping the retarded baby and pre-schooler.

White, C.S., Minor, J.R., and Connolly, B., *eds. A Comprehensive Handbook for Management of Children with Developmental Disabilities.* Memphis, Tenn.: University of Tennessee Center for Health Services, Child Development Center, 1977.

This book makes the basic principles of teaching the developmentally handicapped child understandable to parents, students, direct-care staff, and teachers.

GETTING THE MOST FROM A VIDEO PRESENTATION

An educational television program can be an effective and stimulating learning resource. Because of its ability to convey information and meaning through scenes and sounds, television is one of the most effective classroom tools at your disposal. In addition, support materials are available for a number of ACCESS NETWORK programs. Many of these materials—which include student/teacher guides and manuals, slides, transparencies, filmstrips, posters, etc.—contain suggestions for previewing and post-viewing activities.

Many teachers have found that the effectiveness of video programming can be enhanced in the following ways:

1. Use the ***stop*** and ***pause*** buttons frequently to highlight program segments. This will help break the passive viewing habit created in students by commercial TV and focus their attention on your purpose for showing the program(s).
2. Use the ***counter*** to prepare for the viewing session. Set it to zero at the start of a program. This will help pinpoint the location of segments to be reviewed later. You can then create a ***log*** by jotting down the counter numbers that correspond to important segments.
3. Be specific about viewing objectives ***before*** showing the program. Students will be able to focus their attention better if they are aware of what to look for in a videotape. Prepare a list of guideline questions on the blackboard or on photocopied handouts. (Be sure to cover all of the questions in post-viewing activity.)
4. Since educational television programs generally include more material than can be digested in a single viewing, show the program in its entirety once and then, after clarifying vocabulary difficulties and reviewing specific learning objectives, show selected portions a second, even a third, time. Again, the stop and pause buttons can be used to allow students to take notes—or focus attention on a particular item of importance.
5. Television programs consist of ***both*** audio and video signals, and viewers often need to be stimulated in order to derive maximum information from both. During the second viewing of a program segment, you can stimulate the development of viewing and listening skills by showing the picture but turning off the sound and asking for recall of audio information. Alternatively, leave the sound on but eliminate the picture.
6. Both for viewing comfort and for note-taking convenience, TV should not be viewed in a dark room. However, light can also be a problem, so the television set should be located to avoid window reflection on the screen. To eliminate ceiling-light reflection, tilt the set forward slightly.
7. Ensure that all students have a clear line of sight to the set. If necessary, alter seating arrangements to give every student a satisfactory view of the screen.
8. Adjust the controls of the TV set to ensure good color balance, adequate brightness, and contrast.
9. In some cases, it is useful to have tapes and equipment available for independent viewing by individual students.

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